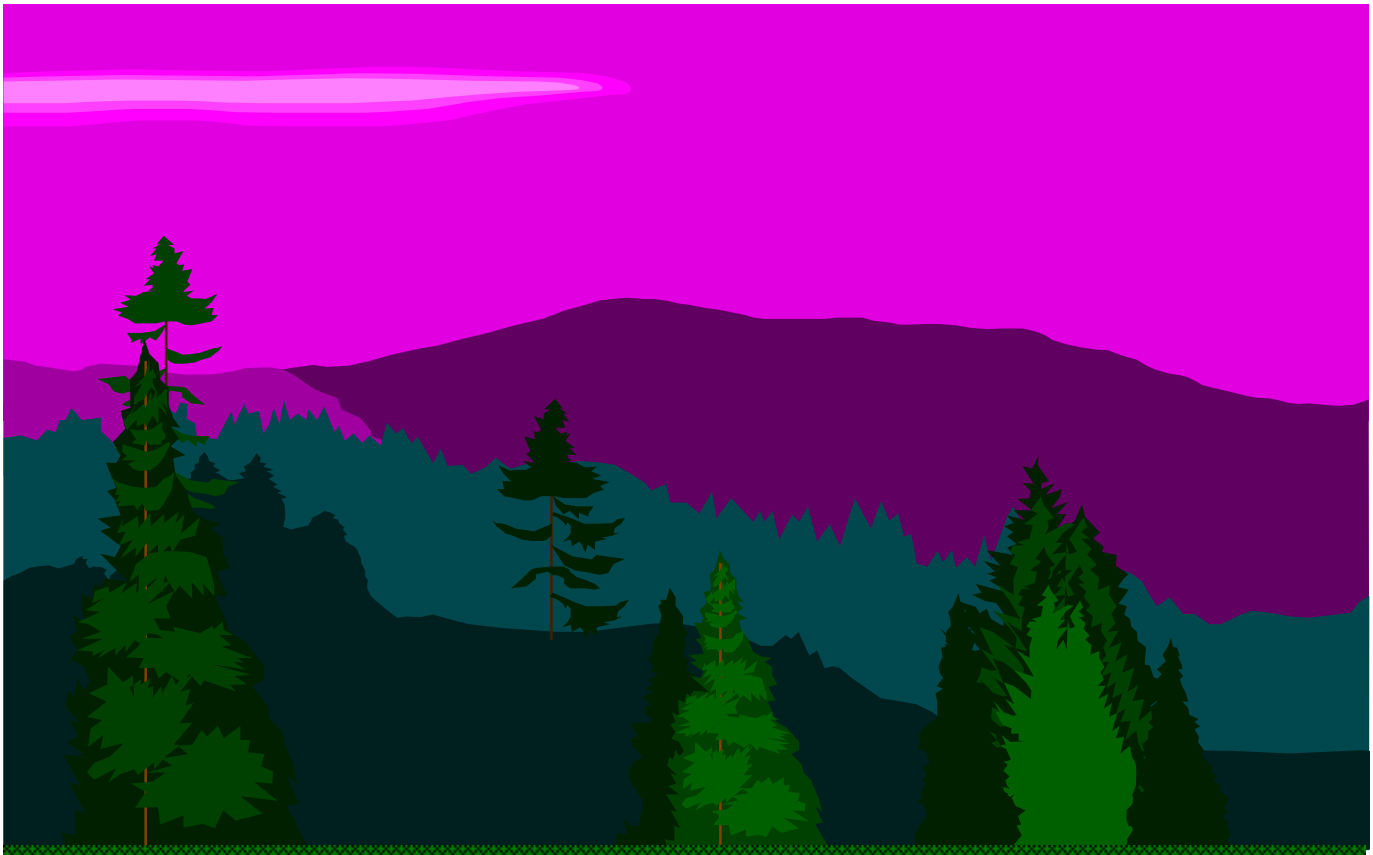

Hancock County Health Council

Community Diagnosis

1997

Community Development - Assessment & Planning
Northeast Tennessee Regional Health Office

Tennessee Department of Health

Introduction

Community Diagnosis is a community-based, community-owned process to assess the health status of Tennesseans. The Hancock County Health Council in cooperation with the Northeast Tennessee Regional Health Office (NETRHO) of the Department of Health identified Hancock County as a pilot county for the community diagnosis process. The Community Development Program of the NETRHO facilitates this community diagnosis assessment process and resulting health planning among all county health councils in the Northeast Tennessee region. The Hancock County Health Council conducted a community survey, reviewed various data sets and evaluated resources in the community to identify areas of concern that affect the health of Hancock County citizens.

Health issues for Hancock County were identified from the data sources and prioritized for size, seriousness, and effectiveness of intervention. As a result of the assessment process, the health council is developing Action Strategies for Hancock County to address the priority problems identified. The Action Strategies Report, to be published next year, will contain goals to improve the health of Hancock County residents.

<u>The Council and Its Mission:</u>

The Hancock County Health Council is a long-standing council made up of members who broadly represent Hancock County (please see Appendix A for a complete list of council members and the diverse areas they represent). All share a strong desire to promote the highest level of health and well being for all residents of Hancock County.

The mission of the council in conducting Community Diagnosis is to develop a community-based, community-owned, and community-directed process to. . .

- **Analyze the health status of the community.**
- **Evaluate health resources, services, and systems of care within the county.**
- **Assess attitudes toward community health services and issues.**
- **Identify priorities, establish goals, and determine courses of action to improve the health status of the community.**
- **Establish a baseline for measuring improvement over time.**

Benefits of Community Diagnosis for the community include:

- **Providing communities the opportunity to participate in directing the course of health services and delivery systems.**
- **Involving communities in development of health strategies which are directly responsive to the community's needs and are locally designed, implemented, and monitored.**
- **Providing justification for budget improvement requests, a foundation of information for seeking grants, and a tool for use in promoting public relations.**
- **Providing, at the local level, current health information and coordination of strategies to the Regional Health Council and to state-level programs and their regional office personnel.**
- **Serving health planning and advocacy needs at the community level. Here the community leaders, organizations, and local health departments provide leadership to ensure that documented community health problems are addressed.**

This document provides a description of community diagnosis activities to-date. Data will be described with emphasis on important issues identified by the council. This report concludes with Hancock County's resulting priority health concerns as identified through the Community Diagnosis process, including enhanced access to a 24-hour care ('hospital-like') facility and both primary and specialty doctors, need for a dental hygienist, chronic diseases (heart disease and stroke), adolescent pregnancy, adult daycare, and maternal care issues to name a few.

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APPENDIX

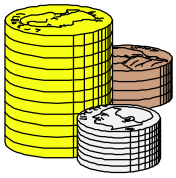
Community Diagnosis

Hancock County Health Council - Community Diagnosis Report
Prepared January 1998 by Community Development/Assessment & Planning Program
Northeast Tennessee Regional Health Office

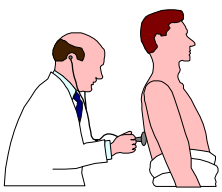
I. County Description

Hancock County is located in Northeast Tennessee bordering the state of Virginia. From an estimated 1996 population of 6,879 people, this county has one incorporated town (Sneedville) of 1,521 people and lies approximately 70 miles northeast of Knoxville. Hancock County has a land area of 222.3 square miles with almost 31 people per square mile. Between 1990 and 1996 the county recorded a 2.1% growth in population. Hancock County's population is predominately white (around 97.5%) with roughly 2.5% of the population classified as minority, and the age distribution of the population is similar to the rest of the state of Tennessee.

The county has two, two-lane highways running through it (Highway 70 and Highway 33). The county has no rail service, bus service, or four-lane highways. Access to the county involves a minimum of a thirty-five minute drive from the nearest large town of Rogersville (which has a population of 4,262). Entry to the county involves crossing two mountain ranges on the curvy, two-lane highways.



Hancock County had a per capita income of $10,369 in 1993 and $10,625 in 1994 for a 2.5% change. The median household income for 1993 was an estimated $14,358. In 1993, an estimated 2,316 people (34.3% of the population) were living in poverty in Hancock County.



Designated a manpower shortage area, Hancock County has no hospitals, three physicians, and one dentist.

II. Needs Assessment Data

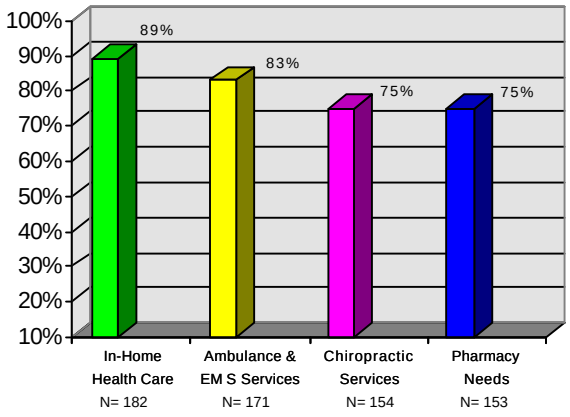
A. Community Stakeholder Survey

The Stakeholder Survey provides a profile of perceived health care needs and problems facing the community stakeholders who respond to the survey. We see council members and other residents alike as having a stake in the overall improvement of this county's health status and health care. This survey includes questions about the adequacy of availability, accessibility, and level of satisfaction regarding health care services in the community. The Community Stakeholder Survey is not a scientific random sample of the community; rather, its purpose is to obtain subjective perceptions of health care from a cross section of the community. It is one of two sources of primary data used in the community diagnosis process.

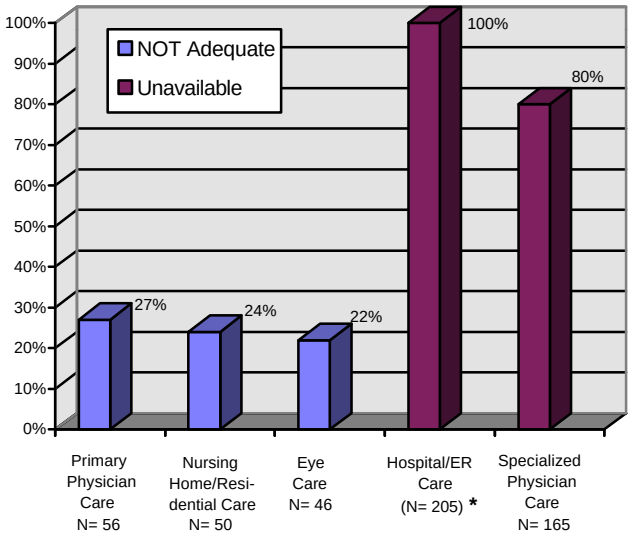
The Stakeholder Survey was distributed to Hancock County Health Council members in addition to a wide variety of community residents. The stakeholders included both the users and providers of health care services.

Of the 205 respondents to the survey, 65% were female. Eighty percent (80%) had lived in the county more than 20 years. About one-half had children in the home.

Of several ***Health Care Services*** in the community, respondents perceived the availability of a vast majority to be *Adequate or Better*. Services considered most adequate in terms of availability by the highest percentages of respondents included:



Health Care Services considered *Available but Not Adequate* (in blue) or completely *Unavailable* (in purple) in the highest percentages of respondents included:



* There is no hospital in Hancock County; residents typically go to Hamblen, Claiborne, & Knox counties for these services.

Most respondents were *Satisfied or Better* with ***Physician Care/Services;*** the only exceptions included 55% of respondents perceiving **obstetrical** services to be *Unavailable* and 52% perceiving **pediatrics** to be *Unavailable*. Thirty percent (30%) were *Not Satisfied* with **laboratory** services. A majority of respondents were *Satisfied or Better* with the ***Local Health Department,*** or held *No Opinion* about their services. The highest percentage who responded otherwise was 18% who perceived **pediatrics** to be *Unavailable* at the health department.

Other areas of importance to the council based on survey results included making the community more aware of, and improving delivery of, the following services:

- mental health services
- alcohol & drug abuse treatment
- child abuse/neglect services
- family planning services.

B. Behavioral Risk Factor Survey

The Behavioral Risk Factor Survey (BRFS) is a scientifically-conducted, random sample telephone survey, weighted to the county's population characteristics. The survey was conducted by the University of Tennessee, Knoxville, Community Health Research Group and is modeled after the BRFS conducted by the Centers for Disease Control. This BRFS collects information from adults on health behaviors and preventive practices related to several leading causes of death such as chronic diseases, injury, and HIV infection.

A sample size of 203 residents was collected from Hancock County, creating a representative sample of county residents for estimating county risk factors. Of the respondents, 52% were female. Compared to results of this same survey in other counties in this region, the 6% of those who reported *never having health care coverage* was very low, but the 47% who felt their *coverage limited the care they received* was the highest in the region.

The council decided to look at the surveyed behaviors in terms of those which most directly impacted their two leading causes of death, *Cardiovascular Disease* and *Cancer*. Four key factors in this survey were identified as concerns for the health of the overall community. The following table lists these factors, comparing the percentages of Hancock County respondents with the average percentages of respondents from the 7 other counties in the Northeast Tennessee region:

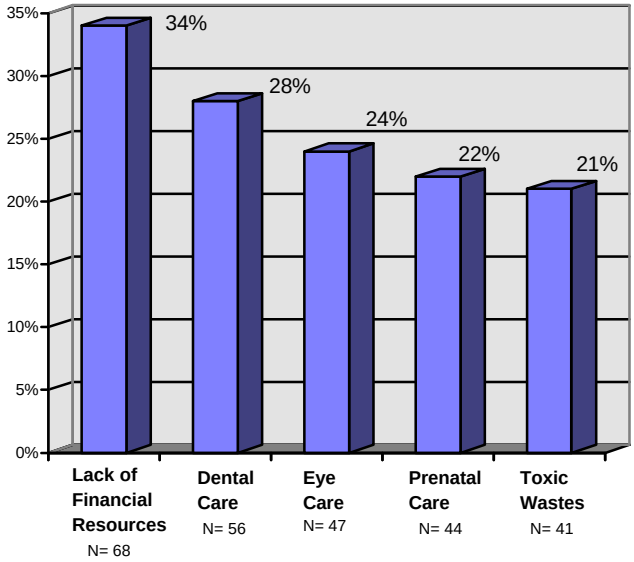
Reported Health Practice	% of Respondents; Hancock County	Average % of Other Respondents; N.E. Region
Smoking; Current, Everyday	33%	27%
Weight*	18%	17%
Had a Check-up Within Last Year	84%	73%
Cost/Need**	24%	16%

* Recently been given advice about Losing Weight

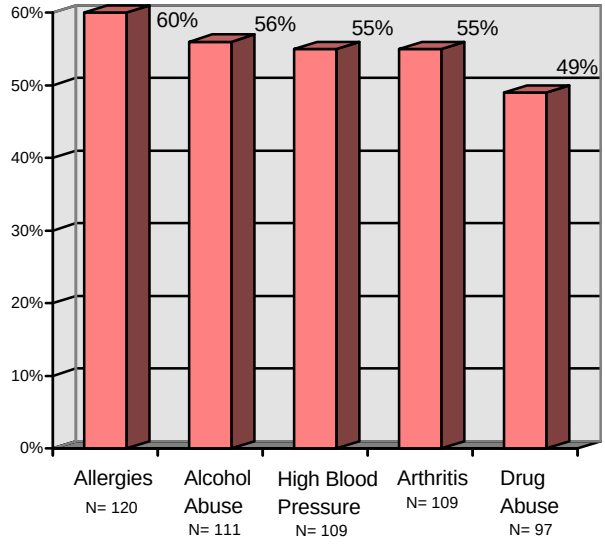
** Have needed to see Dr., but Could Not due to Cost

The BRFS also collects opinion data on ***Access to Health Care/Environmental Issues*** and ***Community Issues.*** The top issues identified by respondents as *Definite Problems* in each category were as follows in the next two charts:

Ch. 1 Access/Environmental Issues: % Saying 'Definite Problem'



Ch. 2 Community Issues: % Saying 'Definite Problem'



Cancer was divided into five separate types in this survey. Since *Cancer* is a leading cause of death in this county, it may be worth noting the following percentages of respondents who considered various types of cancer as *Definite Problems*:

Lung	**25%**
Breast	**24%**
Prostate	**23%**
Colon	**13%**
Cervical	**13%**

Based on the information analyzed in this survey, the council identified two main areas of concern, developing recommendations for addressing the following risk behaviors in order to improve the overall health of community residents:

- **Eating Habits** (to address health problems associated with being overweight & with poor eating habits)
- **Smoking** (including prevention & cessation activities).

C. Health Resource Inventory

The council conducted an inventory of health and health-related services and resources for the primary purpose of identifying any gaps or inadequacies/areas of improvement in services. Several services and resources were found to be available and very adequate for the needs of the community. The council found the following services to be *adequate*, but had various *recommendations* for improving the adequacy, accessibility, or quality of the services:

- Clinics - hours of operation
- Specialty physician referral & care
- Dental care
- Mental health services
- Alcohol & drug abuse *support* services
- Health department outreach efforts
- Optometry/ophthalmology (with regard to transportation services for this health service).

Other areas of health and health-related service were found by the council to be largely

unavailable or in great need of improvement. They were:

- **Civic Organizations:** For those in existence, the council would like to work with them on sponsoring and conducting more health-specific functions; also, there is a great need for establishing an organization such as the United Way, for example, which would allow for county residents working outside of the county to redistribute contributed resources back into their own community.
- **Daycare Services:** Of particular concern were aspects of availability of adult daycare and greater accessibility to youth therapeutic daycare (the closest provision of this service is in a neighboring county and there seem to be some constraints to coverage for transportation).
- **Shelter:** The council noted the unavailability of, and the need for, a shelter for battered/abused women and families.

As a result of this analysis, the council recognized a future need for the development and distribution of a comprehensive directory of health resources.

D. Vital Statistics/Health Status Data

This secondary data (information already collected from other sources for other purposes) provides the council with information about the health status of their community. It was assembled by the State Office of Assessment & Planning and compiled by the Community Development Program, Northeast Region, for the council's analysis.

Vital statistics cover pregnancy & birth, mortality, and morbidity information for the county, region, and state; each set of information is separated into the categories of *All Races, Non-white* and *White*. These statistics are made available in three-year moving averages which smooth trend lines and eliminate wide fluctuations ('spikes' and 'valleys') in year-to-year rates that distort true trends. Ten (10) three-year averages are made available for each health indicator, occurrence, or event for use in examining significant trends in those health indicators. Where applicable, vital statistics comparing the county, region, and state were also compared by the council with the nation's "Healthy People 2000" objectives.

In compiling and analyzing vital statistics for Hancock County, considerations were made for the county's very small population (around 6,800) and the very small percentage of minority population (around 2% - this county's *Non-white* population represented almost exclusively zero data in the vital statistics information sets). Due to the lack of minority data in Hancock County, and because some health indicators and occurrences tend to be more prevalent among minority populations, data for the *White* population of the region and the state was compared with the *All Races* population of Hancock County. Due to the small overall county population, the council had to remain cognizant, as they analyzed this data, of rather high rates per 100,000 (as compared to other counties) only representing very low actual numbers of events.

The council was presented with data on the county, as compared to the region and the state, for the most recent 3-year moving average at the time of analysis, which was the 1992-1994 time period. In addition, unusual or significant fluctuations found in trends within the county - or as compared to the region or state - over the ten sets of 3-year averages (11 year's worth of data) were noted for the council's examination. Such information was provided for the following health status indicators:

- PREGNANCIES (# and rate) by Age of Mother; Wed & Unwed
- LIVE BIRTHS (# and rate) by Age of Mother; Wed & Unwed
- LOW & VERY LOW BIRTHWEIGHT
- LATE/NO PRENATAL CARE
- % Of Births by GESTATIONAL AGE
- % Of Mothers w/Selected RISK FACTORS

- % Of Live Births w/Selected Maternal RISK FACTORS
- PARITY DATA: # of Births w/#s of Previous Live Births
- ENCOUNTER DATA for Programs Serving Children
- MORTALITY RATES:
  - INFANTS
  - NEONATAL
  - POST-NEONATAL
  - CRUDE DEATH RATES
  - YEARS OF LIFE LOST
- LEADING CAUSES OF DEATH: Mortality Rates and Years of Life Lost
- MOTOR VEHICLE (MV) DEATHS
- ACCIDENTAL/NON-MV DEATHS
- VIOLENT DEATHS
- SEXUALLY TRANSMITTED DISEASES
- TUBERCULOSIS
- VACCINE-PREVENTABLE DISEASES
- CANCER: Prevalence and Leading Sites

After the council's analysis of all vital statistics and related health status data, the following areas of particular notice or concern were identified by the council:

➢ Pregnancies Among *15-17 Year Olds;* both *Wed & Unwed:* **(Tables 1 & 2)**

➢ One-third ($^1/_3$) of Live Births Experienced Problems with *Birthweight* or *Prenatal Care:* **(Table 3)**

➢ Percentages of Mothers with Following *Risk Factors-* *Education < 9 Years*
Education of 9-11 Yrs.
Parity of 4+
(Table 4)

➢ Percentages of Births Impacted by the Following *Maternal Risk Factors-*
Mother's Weight Gain < 15 Lbs.
High Parity of Mothers 30+ Yrs. Old
(Table 5)

➢ Rates of *Stroke* & *Malignant Neoplasms* for *Ages 25-44:* **(Table 6)**

➢ *Accident Rate* for *Ages 45-64:* **(Table 6)**

➢ *Diseases of the Heart* for *Ages 65+:* **(Table 6)**

➢ *Motor Vehicle Deaths:* **(Table 6)**

➢ *Years of Life Lost* for *Males* are 350 compared to 95 for Females in the county

TABLES 1 & 2- Pregnancies Among 15-17 Year Olds; Wed & Unwed

Age 17 & Younger:	Rate
Hancock County	**53.7** Per 1000 Women
Healthy People 2000	**50.0** Per 1000 Adolescents

Ages 15-17, Hancock:	Pregnancies, % Unwed:
1983-1985	**5.6**
1992-1994	**50***

*almost 800% increase in trend

TABLE 3- Percentage of Births with Following Risk Factors

	Low Birth-weight:	Very Low Birth-weight:	Late/No Prenatal Care
Hancock	**8.7**	**2.8**	**25.6**
Region	**7.3**	**1.1**	**15.1**
State	**7.0**	**1.1**	**14.9**
Healthy People 2000	**5.0**	**1.0**	**10.0**

TABLE 4- Percentage of Mothers (Ages 10-44) with Following Risk Factors

	County	Region	State
Education < 9 Years	**9.8***	**3.6**	**3.4**
Education of 9-11 Years	**30.3****	**23.1**	**18.9**
Parity of 4+	**4.7^**	**1.6**	**1.7**

* trend decrease from 17.6% since 1983-85
** slight trend increase from 26% since 1983-85
^ slight trend decrease from 6.6% since 1983-85

TABLE 5- Percentage of Live Births with Following Maternal Risk Factors

	County	Region	State
Mother's Weight Gain < 15 Lbs.:			
All Ages	**16.1***	**9.0**	**7.3**
10-17 Years	**33.3***	**6.2**	**5.8**
18-19 Years	**12.5***	**8.0**	**6.4**
High Parity of Mothers Ages 30+	**15.6****	**4.9**	**4.4**

* all represent steady & large trend increases (by 60% to 116%) since 1989-91

** trend decrease from 32% since 1983-85

TABLE 6- Mortality Rates (per 100,000) for Following Causes & Age Groups*

	County	Region	State
Crude Death Rates; All Ages	**11.4**	**10.8**	**9.9**
Stroke (Ages 25-44)	**35.4**	**8.3**	**5.9**
Malignant Neoplasms (25-44)	**70.9**	**34.1**	**31.3**
Accidents/Adverse Effects:			
(Ages 15-24)	**110.1**	**67.6**	**54.3**
(Ages 25-44)	**88.6**	**45.2**	**43.0**
Ages 45-64	**91.4**	**38.7**	**37.4**
Diseases of the Heart (Ages 65+)	**2705.3**	**1953.7**	**1970**
Motor Vehicle Deaths; All Ages	**50.1****	**26.0**	**25.4**

* the above region & state rates are for *All Races*

** steady trend increase since 1986-88; this compares with a Healthy People 2000 rate of **17.8**

E. Other Secondary Data Sources

In addition to sources of data already cited, the Hancock County Health Council used information from other various sources, weighing the information and statistics analyzed against county demographics, manpower information, managed care information, and utilization information. Currently, the council continues to assess more and more current information from these additional sources in planning and reassessment of changes in the health of the community.

Some of the additional sources of information which contributed, and continues to contribute, to the council's diagnosis of health status and health care in Hancock County include: the First Tennessee Development District "FACTS" Publication; the Tennessee Commission on Children and Youth "Kids Count" report; the U.S. Department of Commerce/Bureau of the Census; the Tennessee Department of Health (TDH)/Office of Health Statistics & Information "Tennessee's Health: Picture of the Present" report; the TDH & University of Tennessee Community Health Research Group "HIT" Internet Website.

Please visit the Health Information of Tennessee ('HIT') website where county-specific health data is continually being expanded and updated. The address is:

WWW.SERVER.TO/HIT

At this address you may submit custom queries on health data by going to Statistical Profiling of Tennessee ('SPOT').

III. Health Issues & Priorities

After a review of available data, the council compiled and defined key health issues which had been identified throughout the Community Diagnosis process. These issues included (not listed in order of importance or severity):

24-Hour Care ('Hospital-Like') Facility
Specialty Doctors
Primary Care Doctors (greater access)
Additional Dentist or Dental Hygienist
Speech & Occupational Therapy
Adult Day Care & Youth Therapeutic Daycare
Shelter
Holding Facility for Youth
Civic Organizations
Eating Habits/Smoking (continue & expand education)
Pregnancies Among 15-17 Year-Olds
Low/Very Low Birthweight Babies
Inadequate Prenatal Care

Mom's Low Weight Gain
Stroke
Malignant Neoplasms
Accident Rate for 45-65 Year-Olds
Disease of Heart (particularly for ages 65+)
Motor Vehicle & Violent Death Rates

The council then prioritized these key issues on the basis of the size of population impacted, the seriousness of the health concern, and the effectiveness of potential interventions. Because of the first-hand knowledge council members possessed about various key health issues and their familiarity with effects key health issues had on their community, a relatively straightforward process of multi-voting was used to rank issues in order of priority for being addressed through strategic planning efforts.

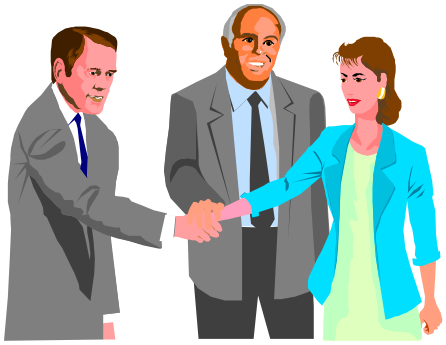
The following ordered list of priority health concerns was rendered by the Hancock County Health Council through the initial Community Diagnosis assessment process:

Priority Health Concerns:

- ✓ **24-Hour Emergent Care / "Hospital-Like" Facility**
- ✓ **Primary Care & Specialty Doctors - (Enhanced Access)**
- ✓ **Need for Dental Hygienist**
- ✓ **Chronic Diseases: Diseases of the Heart**
  Stroke
- ✓ **Adolescent Pregnancy**
- ✓ **Adult Daycare**
- ✓ **Maternal Care:**
  Low Birthweight Babies
  Inadequate Prenatal Care
  Mothers' Low Weight Gain
- ✓ **Healthy Eating Habits & Smoking Cessation**
- ✓ **Holding Facility for Youth**

IV. Future Health Planning

The Hancock County Health Council slated a strategic planning subcommittee to be responsible for laying groundwork on action strategies to address the above priority concerns. Their groundwork will then be taken to the full council for development and approval. With the council's assessment efforts documented herein, a natural progression of future efforts will include a later document describing the council's action strategies and a further document reporting results of those strategies, any changes in related health indicators, and any changes in vital statistics trends or health care services.



APPENDIX

APPENDIX A

The Hancock County Health Council:

Paulette Reed (Chairperson)	***Hancock County School-Based Clinic***
Geneva Anderson	***Citizens Bank of East TN***
Kimberly Belcher	***Clinch-Powell Education Co-op***
Martha Brooks	***Mental Health Representative***
Christopher Brown, D.D.S.	***Hancock County Dental Clinic***
Ike Gibson	***Dept. of Human Services***
Michael Gibson	***Alcohol & Drug Abuse Prevention Representative***
Al Grant	***Rural Health Association Representative***
Michael Harrison	***Hancock County Executive***
Diantha Hodges	***Jubilee Project***
Fern Keaton	***Hancock County High School***
Rebecca Layman	***Hancock County Agricultural Extension Agency***
Gregg Marion	***Hancock County EMS***
Brenda Maxey	***Hancock County Health Department***
Sally Morris	***Hancock County Health Department***
Jack Mullins	***Job Training Partnership Act***
Truett Pierce, M.D.	***Local Provider***
Sherri Ramsey	***Hancock County Medical Center***
Paul Reed, M.D.	***Local Provider***
Glenn Sheddan	***Hancock County Health Department***
John Short, M.D.	***Local Provider***
Lynn Southern	***Home Health Care***
Frances Trent	***First Claiborne Bank***

❖ ***For more information about the Community Diagnosis assessment process, please contact council members or the Northeast Community Development Staff at (423) 439-5900.***